DEFENSE CENTERS OF EXCELLENCE
For Psychological Health & Traumatic Brain Injury

Today's webinar is:

Psychological Health Issues in the National Guard and Reserves: Prevalence, Barriers and Treatment

May 16, 2013, 1-2:30 p.m. (EDT)

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Moderator: George Lamb, LCSW
Social Work Consultant; Outreach Chief, Public Affairs, Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury

DVBIC Defense and Veterans Brain Injury Center
DHCC Deployment Health Clinical Center
National Center for Telehealth & Technology

Webinar Details

- Live closed captioning is now available through federal relay conference captioning (see the pod beneath the presentation slides).
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  - Use participant pass code: **3938468#**
- Webinar information
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- DCoE's awarding of continuing education (CE) credit is limited in scope to health care providers who actively provide psychological health and traumatic brain injury care to active-duty U.S. service members, reservists, National Guardsmen, military veterans and/or their families.
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Psychological Health Issues in the National Guard and Reserves: Prevalence, Barriers and Treatment

- Reserve component (i.e., National Guard and reserves) service members play a vital role with more than 123,000 reserve component service members activated in the Operation Enduring Freedom/ Operation Iraqi Freedom missions.
- Reserve components face many challenges active components do not. For example, reserve components transition from military to civilian life frequently, balancing the demands of both military life and civilian life.
- Research has suggested that reserve components may have different health concerns (e.g., physical and psychological) compared to active components.

This webinar will:

- Examine the various psychological health problems experienced by reserve components
- Identify challenges facing reserve components to accessing care
- Present treatment recommendations for working with reserve components

Psychological Health Issues in the National Guard and Reserves: Prevalence, Barriers and Treatment

M. Tracie Shea Ph.D.

- Psychologist and Director of PTSD Research at the Providence Veterans Affairs Medical Center
- Professor, Department of Psychiatry and Human Behavior at Brown University

Disclaimer

I have no relevant financial relationships to disclose

Background

- Approximately 2.3 million service members have been deployed as part of OEF (Afghanistan) and OIF (Iraq)
- Approximately 665,000 (29%) have been National Guard/Reserve (NG/R)
- At the highest point, NG/R constituted 40% of total deployed

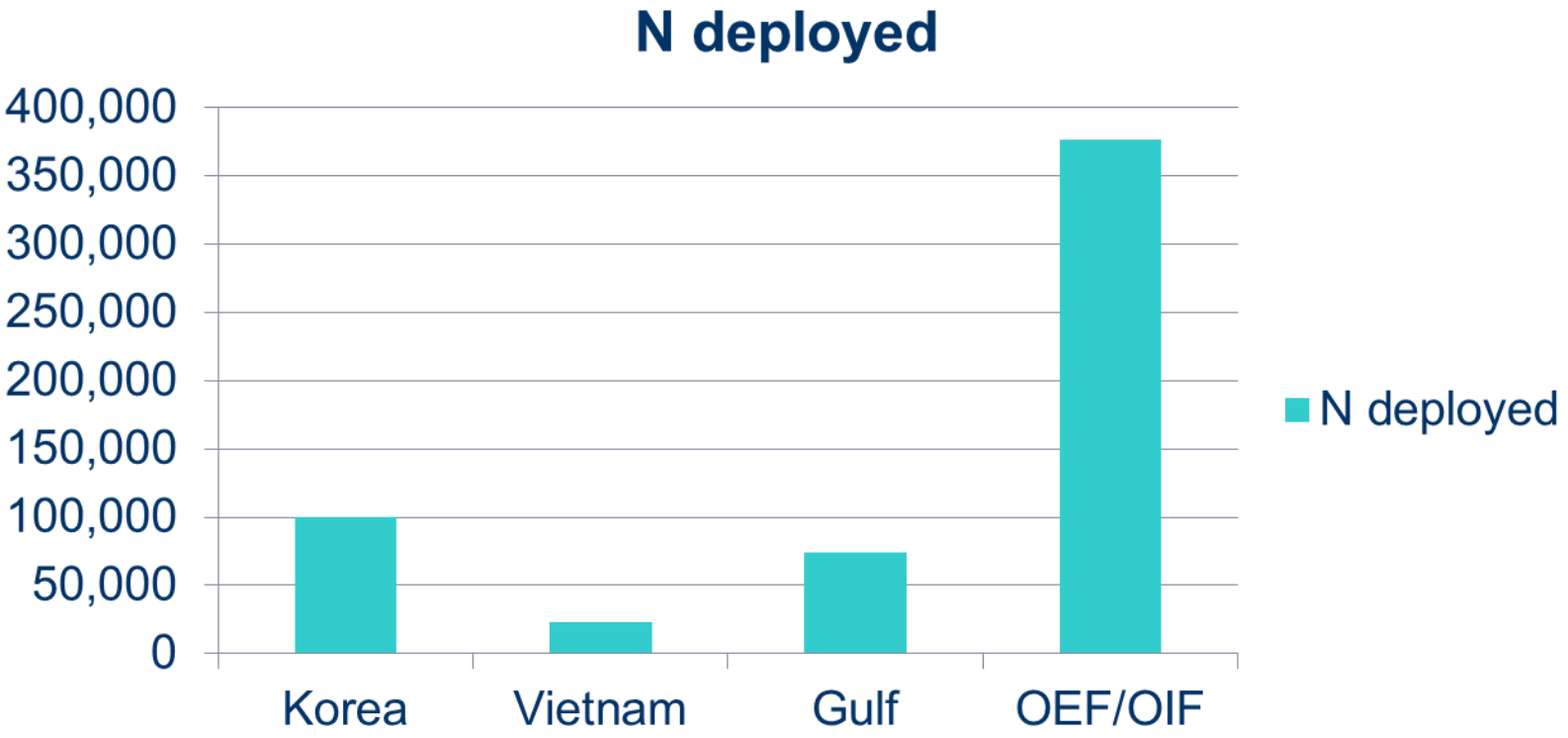
Notes: OEF = Operation Enduring Freedom, OIF = Operation Iraqi Freedom

Background

- Pace of deployments unprecedented in history of all-volunteer force
  - Higher proportion of armed forces being deployed
  - Deployments have been longer
  - Multiple deployments common
  - Breaks between deployments often short
  - Larger proportion of deployed troops: National Guard or Reserve

Reference: Belasco, 2007

Number of NG/R deployed in different wars



Objectives

- Examine various post-deployment psychological health problems experienced by NG/R members
- Identify challenges for NG/R members to access care
- Discuss treatment considerations and recommendations for working with NG/R members

Overview of Presentation

- Nature of Stressors
  - Warzone exposure
  - Additional stressors for NG/R
- Psychological Health Problems
  - Posttraumatic Stress Disorder (PTSD), depression
  - Substance abuse
  - Anger and aggression
  - Interpersonal conflict / relationship problems
  - Reintegrating into civilian society

Overview of Presentation

- Accessing Mental Health Care
  - Mental Health Service (MHS) utilization
  - Barriers to accessing care
- Treatment Considerations
  - Engagement and rapport
  - Social support and life stress
  - Treatments approaches (PTSD, marital conflict, guilt)

Nature of Stressors: Warzone

Photo Credit: USMC SSgt Emanuel Melton

Nature of Warzone Stressors

- Difficult living/working environment
  - Poor food
  - Lack of privacy
  - Uncomfortable climate
  - Boredom
  - Extreme physical exertion, exhaustion

Nature of Warzone Stressors

- **Personal risk of injury/death**
  - Ongoing threat of attack (mortars, rockets, small arms, snipers)
  - IEDs, suicide bombers
  - Urban warfare

Photo Credit: USAF Senior Airman Grover Fuentes-Contreras

Notes: IED = Improvised Explosive Device

Nature of Warzone Stressors

- **Witnessing injury, suffering, death and violence**
  - Seeing close friends seriously injured/killed
  - Witnessing death on large scale – enemy and civilians
  - Witnessing the aftermath of battle – dead and mutilated bodies, horrific injuries, devastated homes and communities
  - Handling human remains
  - Witnessing violence, including unnecessary violence

Nature of Warzone Stressors

- **Inflicting injury and death—killing**
  - Enemy
  - Civilians
  - Friendly fire

Nature of Warzone Stressors

Quote from an Army Chaplain serving outside Mosul, Iraq (counseling 8 to 10 soldiers a week for combat stress):

> "There are usually two things they are dealing with…Either being shot at and not wanting to get shot at again, or after shooting someone, asking, 'Did I commit murder?' or 'Is God going to forgive me?'"

Source: New York Times article December 16, 2004

Additional NG/R Stressors

- Less preparation for active duty
- More likely to have family and civilian work responsibilities
- Less support for families while deployed
- Returning to communities with less awareness or appreciation of military service

Additional NG/R Stressors

- Not embedded with military units after deployment – lower levels of post-deployment support
- Less stable employment – financial stress

Psychological Health Problems

Consequences of Trauma

"We have begun to appreciate the profound and sometimes irreversible changes produced by overwhelming stress. These include fundamental alterations in perception, cognition, behavior, emotional reactivity, brain function, personal identity, worldview, and spiritual beliefs."

– *Matthew J. Friedman, M.D., Ph.D.*

Reference: The New England Journal of Medicine, 2005

Mental Health Diagnoses/Symptoms

- PTSD
- Depression
- Alcohol misuse
- Anger and aggression

Photo Credit: USN Seaman Tina Staffieri, DOD

Prevalence of Mental Health Problems

- Prevalence rates vary
  - Different measures
  - Different case definitions
  - Timing of assessment
  - Amount of combat/trauma exposure

Studies Comparing Active and National Guard/Reserve Samples

- Milliken C.S., Auchterlonie J.L., Hoge C.W. (2007) *Longitudinal Assessment of Mental Health Problems Among Active and Reserve Component Soldiers Returning From the Iraq War.* JAMA 298 (18) 2141-2148
- Thomas J.T., Wilk J.E., Riviere et al., (2010) *Prevalence of Mental Health Problems and Functional Impairment Among Active Component and National Guard Soldiers 3 and 12 Months Following Combat* in Iraq. Arch. Gen. Psychiatry 67 (6) 614-623

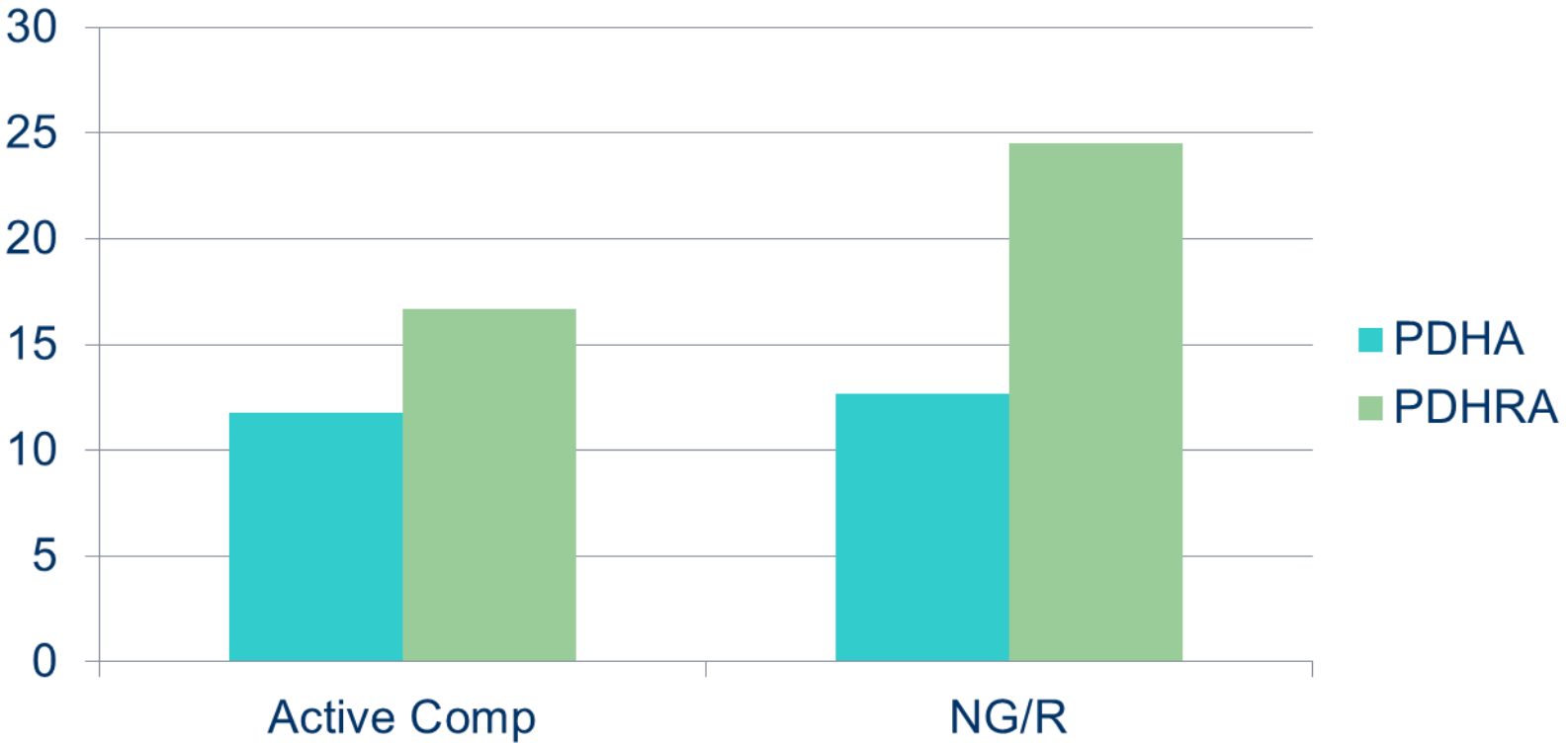
Assessment of Mental Health

- Initial sample of 88,235 soldiers returning from Iraq who completed initial assessment (PDHA) and reassessment (PDHRA)
  - Active Component (AC): 56,350
  - NG/R: 31,885
- PDHRA median of 6 months following initial PDHA
- Assessments not anonymous

Notes: PDHA = Post Deployment Health Assessment , PDHRA = Post Deployment Health Reassessment

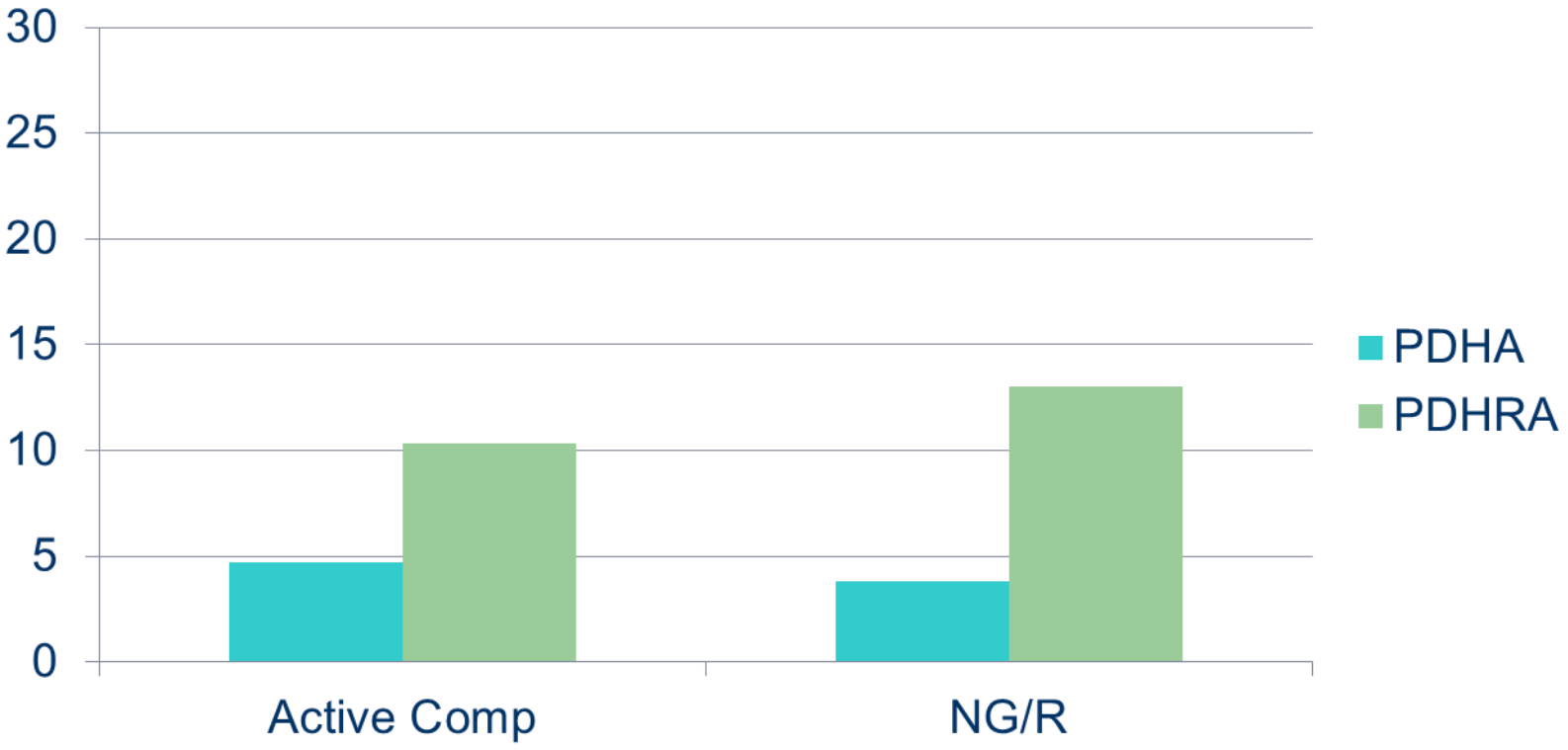
Reference: Milliken et al., 2007

Positive Screen for PTSD (primary care screen)



Reference: Milliken et al., 2007

Positive Screen for Depression (PHQ-2)



Notes: PHQ = Patient Health Questionnaire

Reference: Milliken et al., 2007

Mental Health Problems and Referrals

	AC	NG/R
(N)	*(56,350)*	*(31,885)*
• Any MH problem	20.3%	42.4%
• Positive alcohol screen	11.8%	15.0%
• Referred for MH care	17.7%	40.7%

Notes: MH = Mental Health

Reference: Milliken et al., 2007

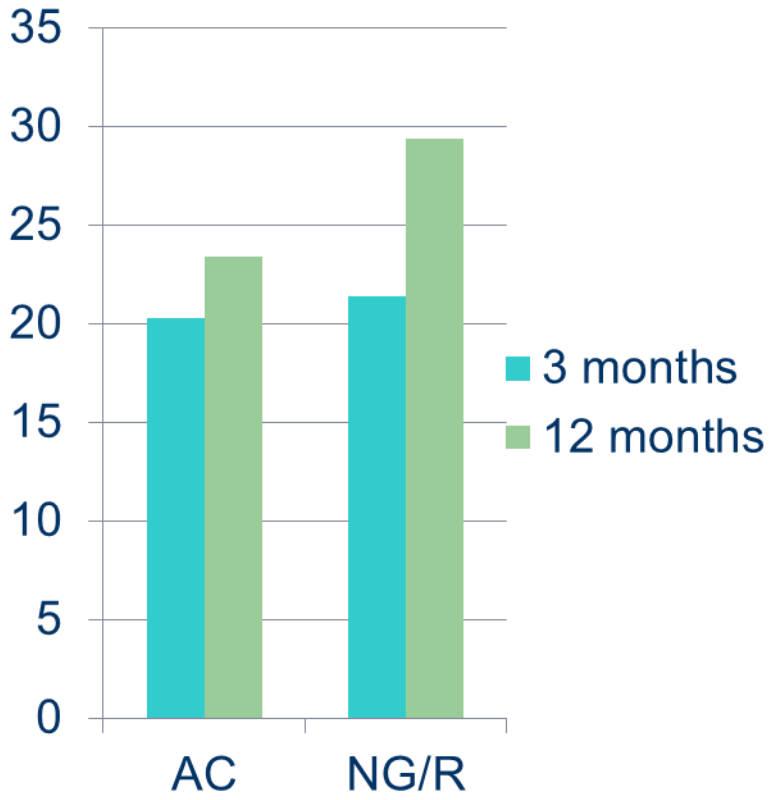
Prevalence of Mental Health Problems

- Examine rates of PTSD and depression using different case definitions
- Compare rates between AC and NG/R at 3 and 12 months post-deployment
- Anonymous surveys
- Total sample of 13,226 AC and NG/R soldiers across two time points

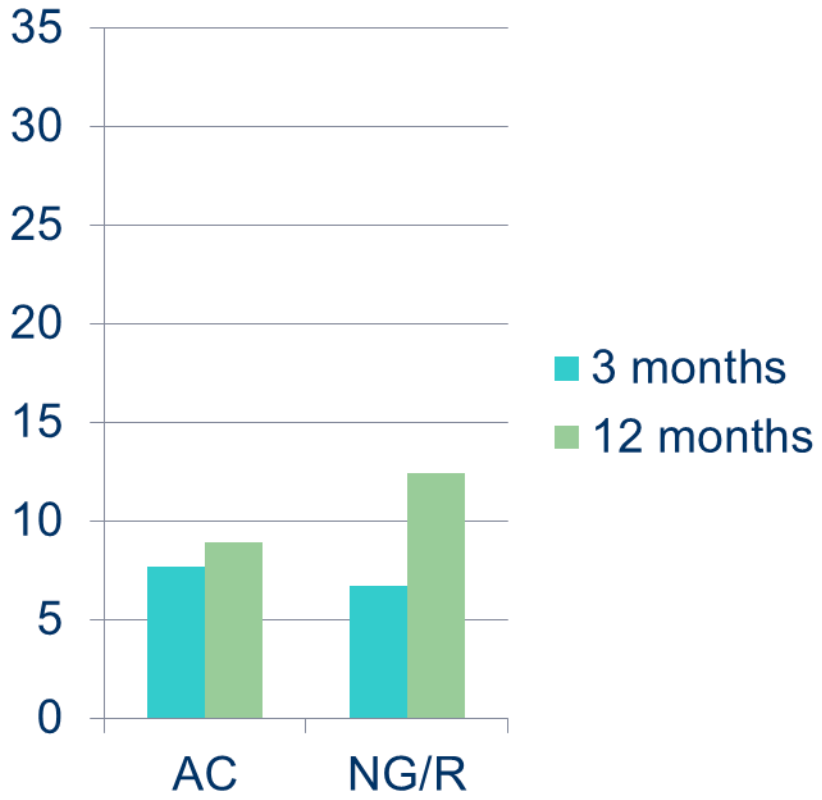
Reference: Thomas et al., 2010

PTSD using PTSD Checklist

Some functional impairment



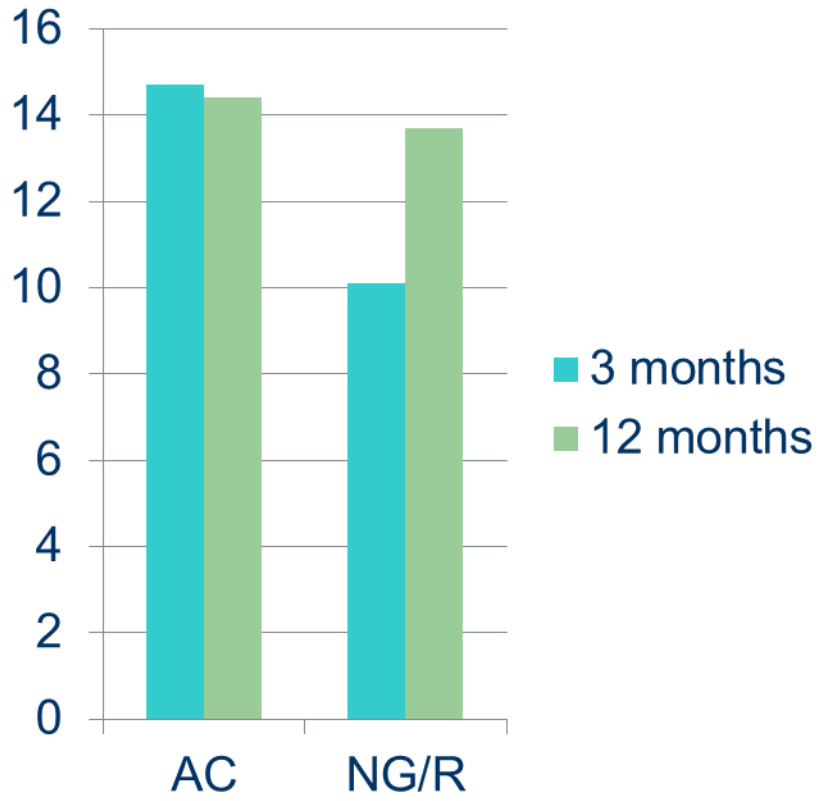
Serious functional impairment



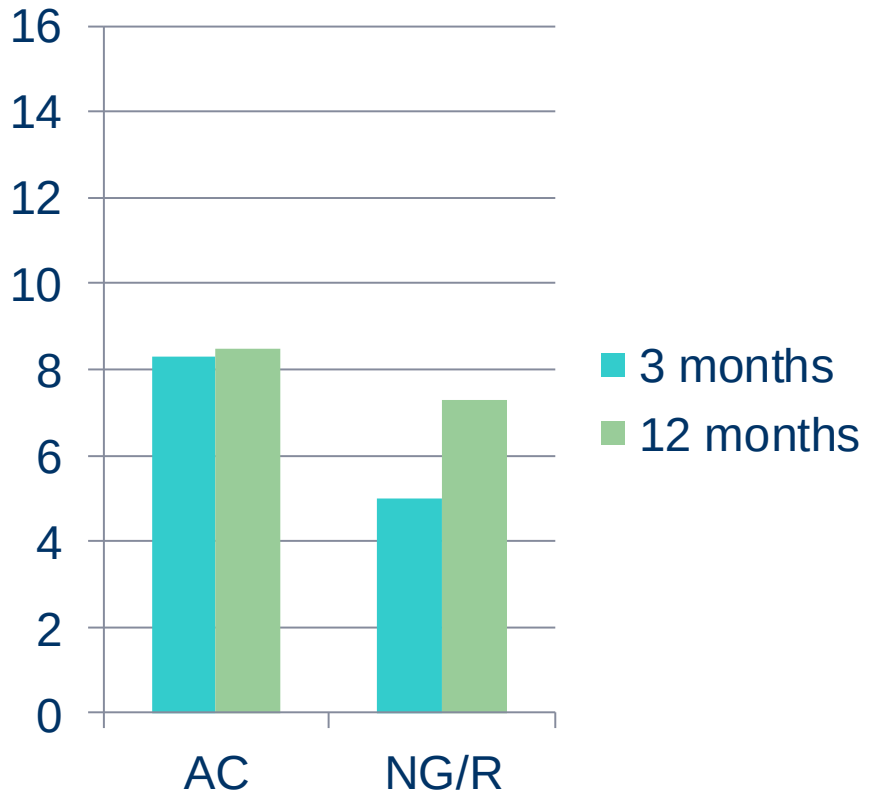
Reference: Thomas et al., 2010

Depression Using the PHQ

Some functional impairment



Serious functional impairment

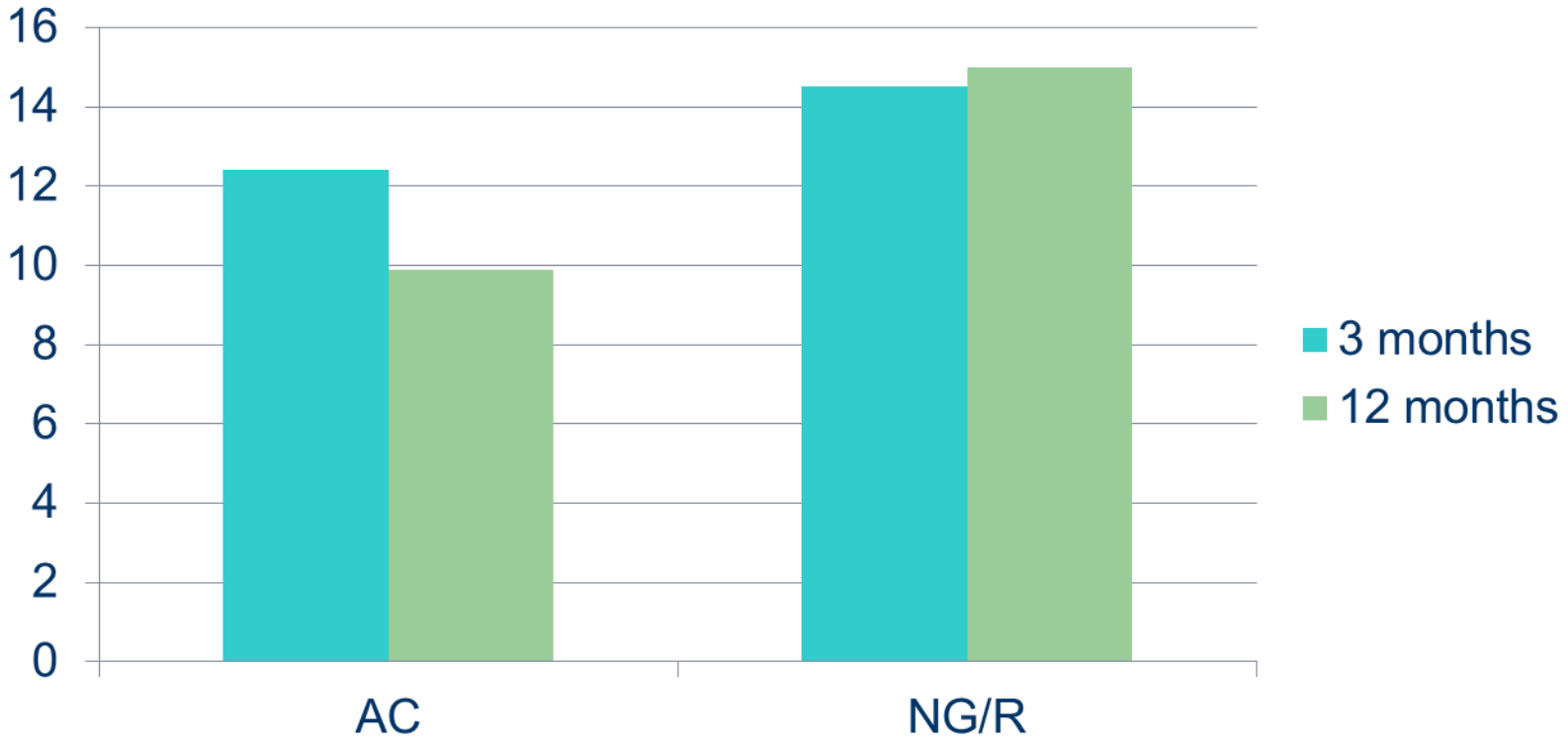


Reference: Thomas et al., 2010

Depression or PTSD (some functional impairment)

Reference: Thomas et al., 2010

Alcohol Misuse



Reference: Thomas et al., 2010

Summary: Estimate Rates of Mental Health Disorders in NG/R

PTSD:	7 to 29%
Depression:	5 to 15%
Alcohol misuse:	10 to 15%
Any MH problem:	42%

PTSD Symptoms

- Sample of NG/R recruited from PDHA/PDHRAs
- Assessed with structured interview (CAPS)
- Repeat assessments

Notes: CAPS = Clinician-Administered PTSD Scale

Reference: Shea et al., 2010

Frequency of Individual PTSD Symptoms at Month 01

- Re-experiencing
  - Intrusive memories 13%
  - Nightmares 17%
  - Flashbacks 9%
  - Psychological distress reminders 15%
  - Physiological reactivity 12%

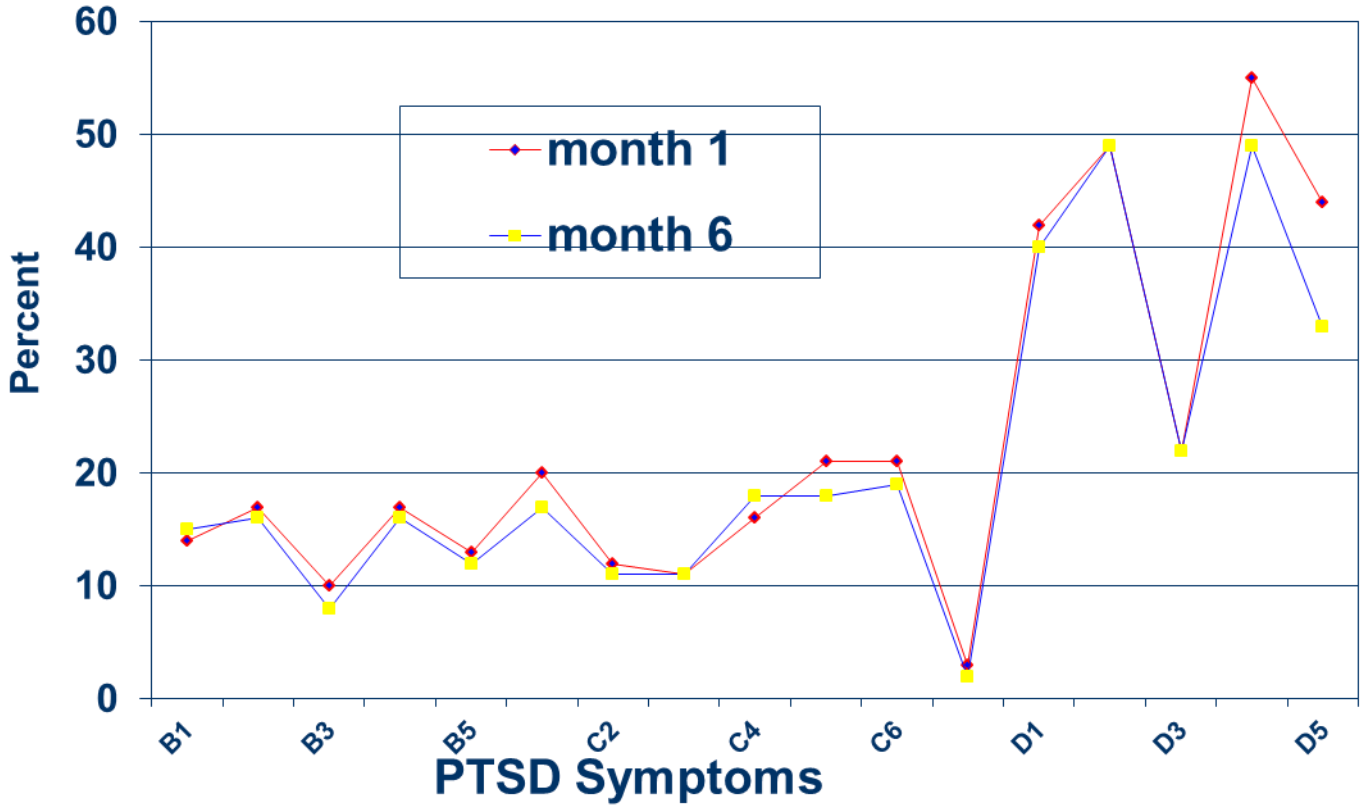
Frequency of Individual PTSD Symptoms at Month 01

- Numbing / Avoidance
  - Avoid thoughts / feelings 19%
  - Avoid activity / people / places 12%
  - Inability to recall 10%
  - Diminished interest 16%
  - Feeling detached / estranged 21%
  - Restricted affect 21%
  - Foreshortened future 2%

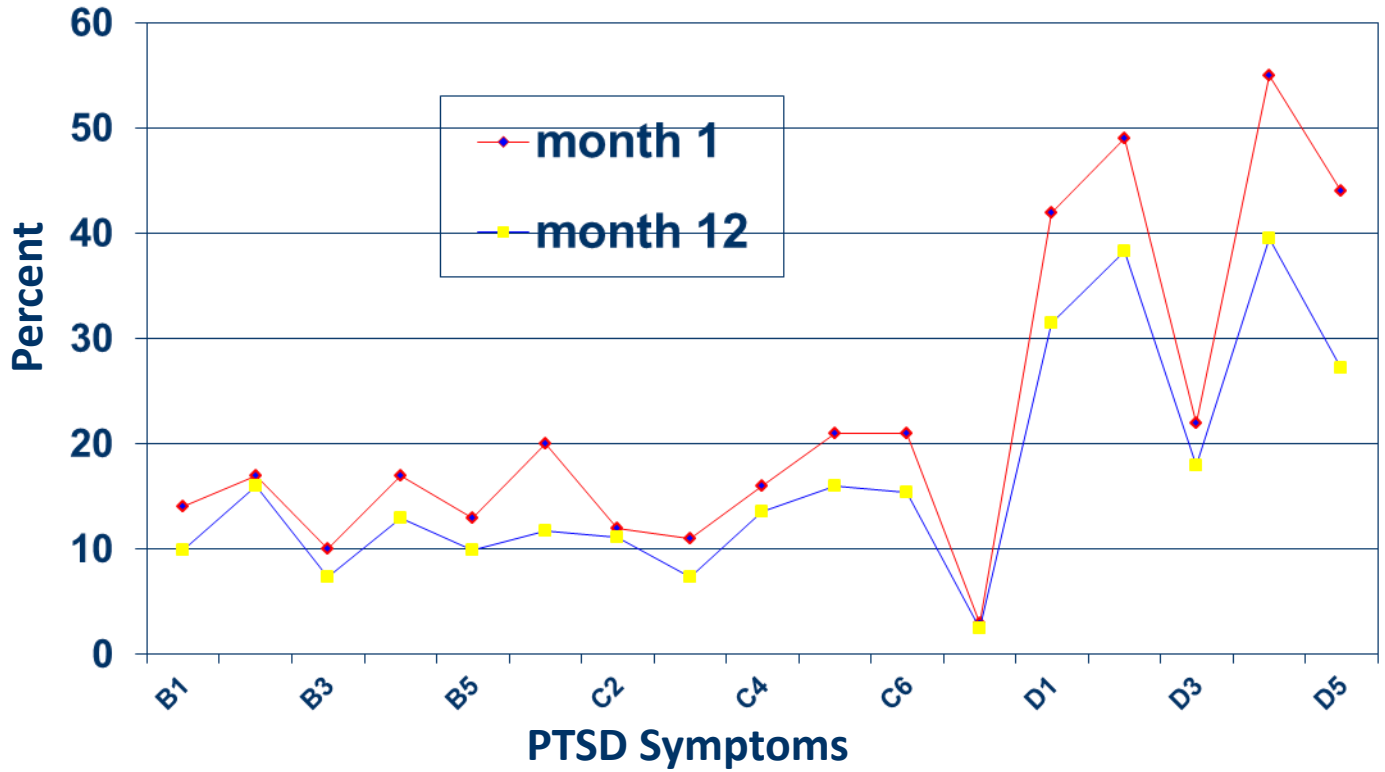
Frequency of Individual PTSD Symptoms at Month 01

- Hyperarousal
  - Difficulty sleeping 43%
  - Irritability/anger 50%
  - Difficulty concentrating 21%
  - Hypervigilance 55%
  - Exaggerated startle 43%

Persistence of Symptoms: Frequency of PTSD Symptoms Months 1 and 6 Post Return (n=194)



Frequency of CAPS Rated PTSD Symptoms Months 1 and 12 Post Return (n=162)

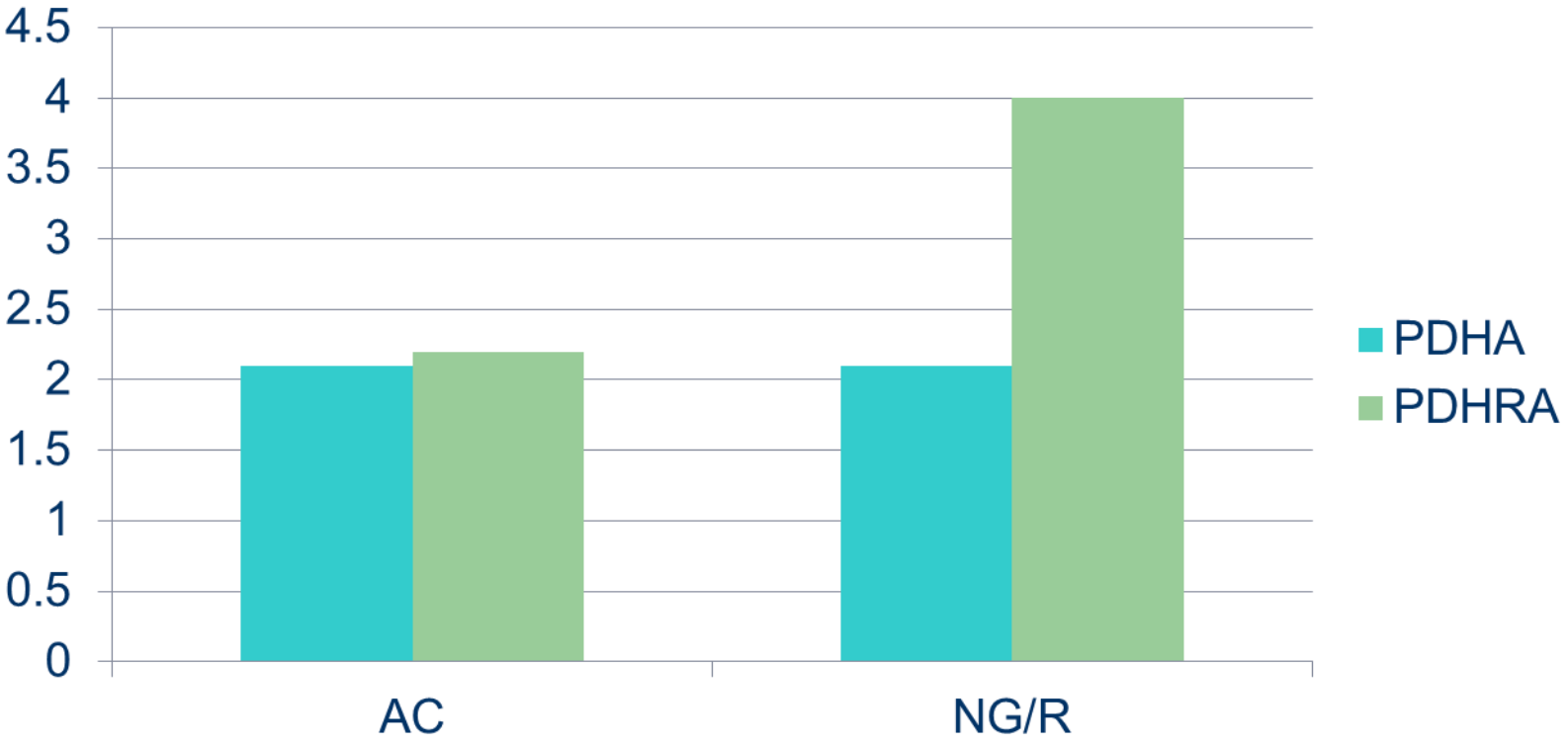


Summary: Mental Health Disorders and Symptoms

- Rates of PTSD and any mental disorder tend to be higher in NG/R than AC
- Rates tend to increase with later assessments
- Increases over time for NG/R tend to be larger than for AC
- Hyperarousal symptoms are common and persist even in those who do not have PTSD

Anger/Aggression

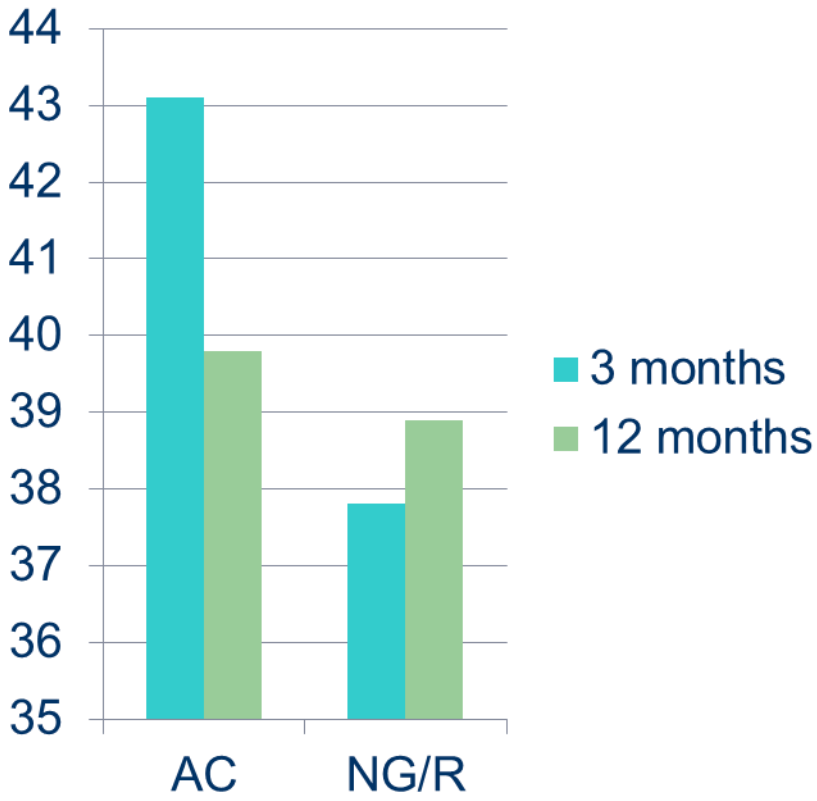
Interpersonal Aggressive Ideation



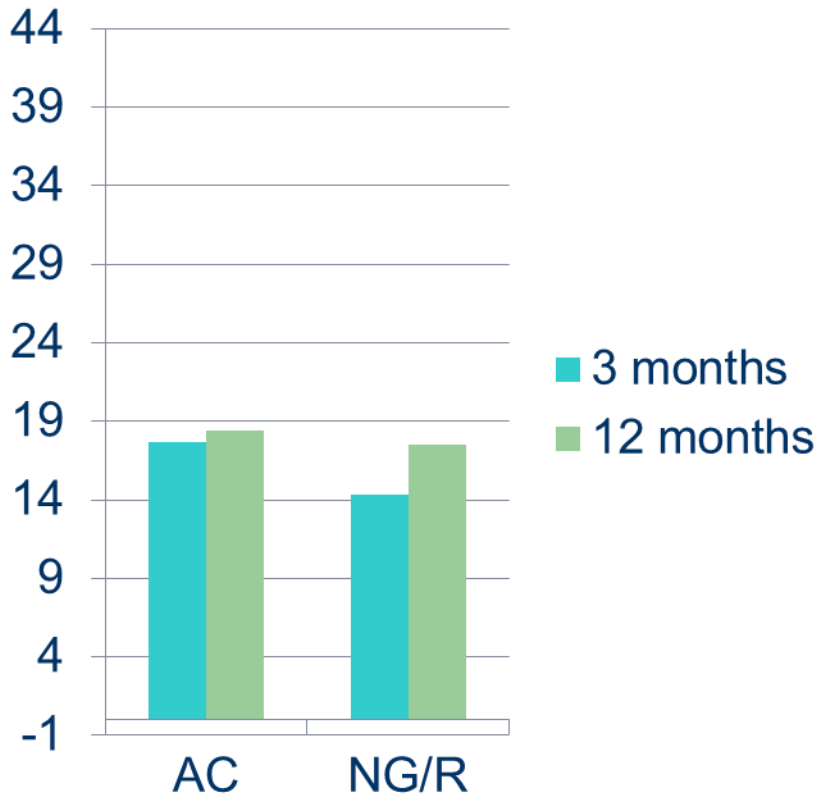
Reference: Milliken et al., 2007

Aggression

Kick, smash or punch something



Get into fight and hit someone



Reference: Thomas et al., 2010

Anger and Aggression

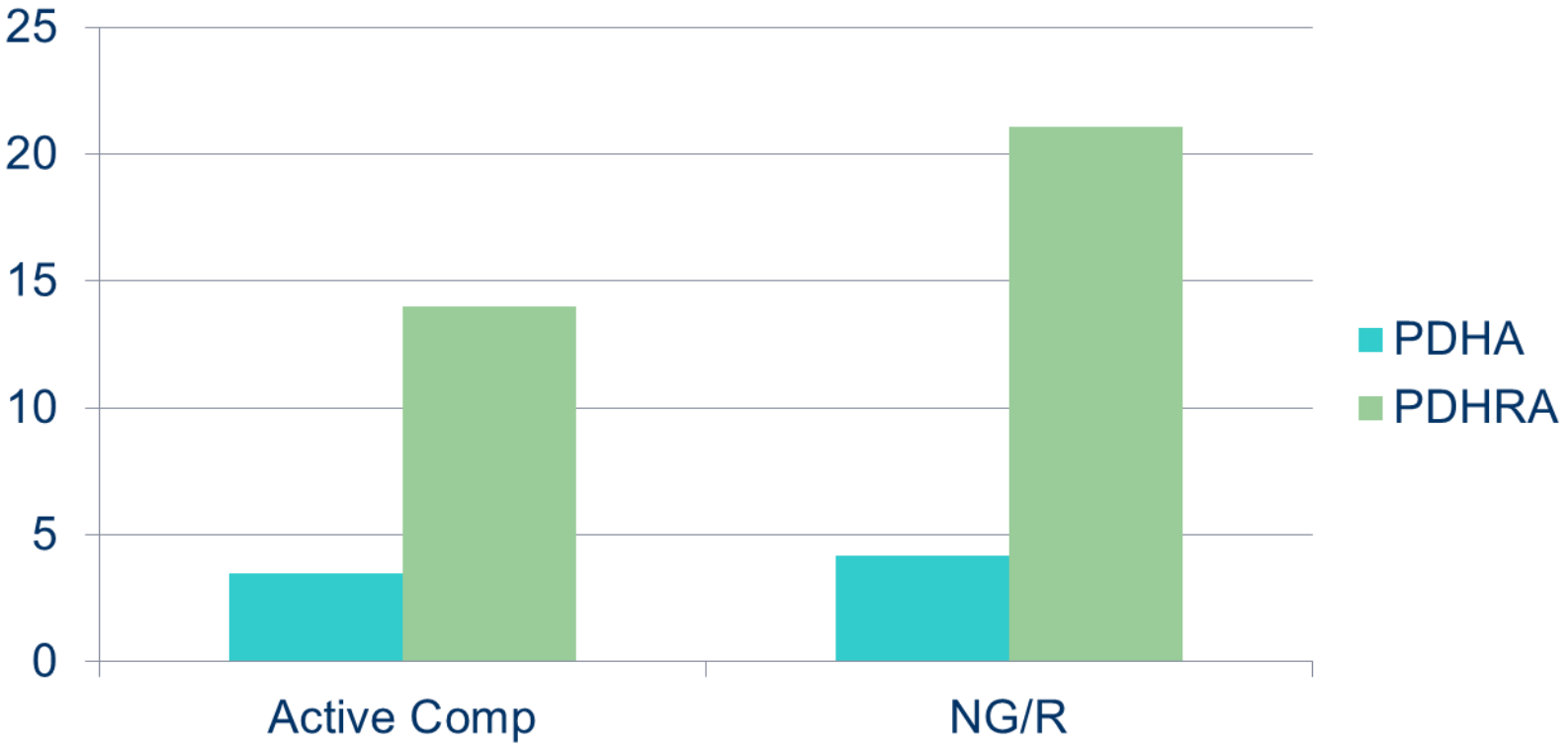
- Sample of 724 OEF/OIF combat veterans receiving VA medical care (median of 42 months post deployment)
- Percent with:
  - More problems controlling anger 57%
  - Thoughts or concerns about hurting someone 35%

Reference: Sayer et al., 2010

Interpersonal Conflict and Relationship Issues

Photo Credit: USN Specialist 1st Class Rebecca Kruck

Interpersonal Conflict



Reference: Milliken et al., 2007

Interpersonal Conflict

- 97 National Guard Soldiers (recruited from soldier readiness training)
- 42 with partners and 36 with children
  - Unhappy in romantic relationship 26.2%
  - Concerns about getting along with spouse/partner 73.8%
  - Concerns about getting along with children 69.4%
  - Parenting more stressful after deployment 55.6%

Reference: Khaylis et al., 2011

Interpersonal Conflict

- 724 OEF/OIF combat veterans (AC and NG/R) receiving VA medical care
- Median of 42 months post deployment
- Percent with problems:
  - Getting along with relatives 34%
  - Getting along with spouse/partner 42%
  - Getting along with children 29%

Reference: Sayer et al., 2010

Other Reintegration Problems

- National stratified sample of 754 OEF/OIF combat veterans using VA medical care
- Percent with problems
  - Dealing with strangers 43%
  - Taking part in community activities 49%
  - Belonging in “civilian” society 49%
  - Finding meaning or purpose in life 42%
  - Doing what is needed for work/school 35%
  - Taking care of chores at home 41%

Reference: Sayer et al., 2010

Summary: Psychological Health Problems

Substantial proportion of veterans deployed to Iraq and/or Afghanistan dealing with

- PTSD, depression and alcohol problems
- Increased trouble controlling anger/aggression
- Conflict in relationships, including spouse/partner and children
- Feeling alienated from society, civilians
- Finding meaning or purpose in life

Summary: Psychological Health Problems

- Findings suggest that some of these problems may be frequent in NG/R

Utilization Of Mental Health Services

Samples

- Military settings
- Randomly sampled national surveys
- National VA databases

Samples from Military Settings

- Anonymous survey to 3,671 members of 4 U.S. combat infantry units 3 to 4 months after return from Iraq or Afghanistan
- Of those with responses positive for PTSD, anxiety or depression receiving professional help from any professional:
  - 23% (Afghanistan—Army)
  - 29% (Iraq—Marines)
  - 40% (Iraq—Army)

Reference: Hoge et al., 2004

Samples from Military Settings

- Of those with responses positive for PTSD, anxiety or depression receiving professional help from mental health professional
  - 13% (Afghanistan—Army)
  - 27% (Iraq—Marines)
  - 21% (Iraq—Army)

Reference: Hoge et al., 2004

Samples from Military Settings

- Population-based sample of Army and Marines completing PDHA
- Health care utilization measured for one year after return
- Accessing mental health care:
  - 35% of all Iraq veterans followed
  - 50% of those referred for mental health care

Reference: Hoge et al., 2006

Samples from Military Settings

Surveys completed by 10,386 AC and NG/R soldiers

- 3 months post deployment to Iraq
  - Active duty 13%
  - National Guard/Reserves 17%
- 12 months post deployment to Iraq
  - Active duty 13%
  - National Guard/Reserves 27%

Reference: Kim et al., 2010

Randomly Selected National Samples

- Telephone survey of 1,965 formerly deployed OEF/OIF active duty and NG/R personnel from all service branches
- Of those with probable PTSD or depression 53% sought mental health care
- Most did not receive minimally adequate care (≥ 8 sessions within one year)

Reference: Rand Study: Schell & Marshall 2008

Randomly Selected National Samples

- Mailed surveys 1,388 separated AC or in NG/R
- Median of 4 years post deployment
- Mental health treatment over past year among those positive for:
  - PTSD 69%
  - Depression 67%
  - Alcohol misuse 45%

Reference: Elbogen et al., 2013

OEF/OIF Veterans Receiving Care at VA Facilities (2002-2010)

- Eligible for VA health care: 1.25 million separated from active duty
- About 50% (625,384) obtained VA health care 2002-2010
- Of those obtaining any VA health care
  - 50.2% received a mental health diagnosis
  - 27% diagnosed with PTSD
  - 20% diagnosed with depressive disorder

VA Mental Health Service Utilization

- Percent of OEF/OIF veterans accessing VA medical care receiving at least one mental health visit within first year of diagnosis:
  - Any mental health diagnosis 67%
  - PTSD Dx 80%
  - Non-PTSD mental health Dx 49%

Notes: Dx = Diagnosis

Reference: Seal et al., 2010

VA Mental Health Service Utilization

- OEF/OIF veterans accessing VA medical care with new PTSD diagnosis receiving 9 or more mental health visits:
  - Within ≤ 15 weeks 9.5%
  - Within one year 27%
- Median number of visits in first year: 4

Reference: Seal et al., 2010

Mental Health Treatment Retention

- OEF/OIF Veterans more likely to miss therapy sessions and to drop out of treatment compared to Vietnam Veterans (n=54)
- Proportion of scheduled sessions attended
  - OEF/OIF (n=106) 0.47
  - Vietnam (n=54) 0.71
- Percent dropping out of treatment
  - OEF/OIF 31%
  - Vietnam 15%

Reference: Erbes et al., 2009

Summary: Mental Health Treatment Utilization

- About half of OEF/OIF veterans with mental health problems seek treatment
- Rates may be higher in NG/R
- Among those who start treatment, a large majority do not receive a minimally adequate number of sessions
- Suggests that most are not receiving recommended levels of care

Perceived Barriers to Mental Health Care

- Stigma
- Beliefs about mental health treatment
- Access

Perceived Stigma Among Those With Any Mental Health Disorder

	(n=731)*
• Too embarrassing	41%
• Harm career	50%
• Unit less confidence in me	59%
• Leaders would blame me	51%
• I would be seen as weak	65%

*Soldiers and Marines 3 months post return

Reference: Hoge et al., 2004

Attitudes Toward Mental Health Treatment

- Do not trust mental health professionals 38%
- Mental health care does not work 25%

Reference: Hoge et al., 2004

Perceived Access Barriers

- Do not know where to get help 38%
- Transportation problems 18%
- Difficult to schedule appointment 45%
- Difficult to get time off work 55%
- Costs too much money 25%

Reference: Hoge et al., 2004

Perceived Stigma Among AC and NG/R Soldiers With Any Mental Health Problem

	AC (n=2,023)	NG/R (n=497)
Embarrassing	28%	20%
Harm career	31%	17%
Unit less confidence in me	39%	22%
Leaders blame me for problems	31%	10%
I would be seen as weak	44%	22%

Reference: Kim et al., 2010

Perceived Access Barriers Among AC and NG/R Soldiers With Any Mental Health Problem

	AC	NG/R
• Do not know where to get help	11%	13%
• Transportation problem	8%	18%
• Difficult to schedule appointment	28%	8%
• Difficult to get time off work	34%	20%
• Costs too much money	15%	22%

Reference: Kim et al., 2010

Summary: Barriers to Mental Health Care

- Stigma may be decreasing but remains an important barrier
- Stigma appears to be less of a concern for NG/R than AC
- Difficulty scheduling appointments and getting time off of work to get to appointments most common access barriers

Treatment Considerations

Treatment Relevant Issues

- Difficulty in keeping some OEF/OIF veterans in treatment
- Aside from severity of combat exposure, two most consistent predictors of PTSD:
  - Social support
  - Life stress
- Effective treatments for PTSD
- Marital strain/conflict
- Guilt
- Anger and aggression

Engagement and Rapport

- Flexibility in scheduling appointments (nights and weekends)
- Be alert to negative perceptions about mental health treatment and discuss if appropriate
- Show familiarity with military culture and common experiences of deployed veterans

Engagement and Rapport

- “Conceptualizing PTSD within an occupational context that is much broader than the clinical definition” (Hoge, 2011)
- Some PTSD “symptoms” were highly adaptive in combat (e.g., hyperarousal, hypervigilance, aggressive reactions, being able to shut down emotions, function on limited sleep)
- Example: Battlemind Training Model

Battlemind Training (Walter Reed Army Institute)

From "War zone" to "Home zone"

- **Battlemind** is the Soldier's inner strength to face fear and adversity in combat with courage…
- Combat skills and battle mindset sustained your survival in the *war-zone*…
- But Battlemind may be "hazardous" to your social & behavioral health in the *home zone*…

Battlemind Training

The key to a successful transition home is to adapt your combat skills so that you are just as effective at home as you were in combat.

Increase Support and Decrease Stress

- Monitor isolation and encourage contact with others
- Contact with other veterans (e.g., groups, peer-to-peer support)
- Case management for financial, housing, legal concerns

Recommended Treatments for PTSD

- Trauma Focused / Cognitive Behavioral Treatments recommended by multiple treatment guidelines
- VA providing training in Prolonged Exposure and Cognitive Processing Therapy
- May need to be flexibly applied – not all veterans willing or able immediately to do trauma-focused work

Core Components of Recommended PTSD Therapies

- Psychoeducation
- Trauma “exposure” or narration (written, oral past tense, imaginal present tense)
- Cognitive restructuring (addressing maladaptive beliefs or “stuck points”)
- *In vivo* exposure (confronting avoided places, activities)
- Stress innoculation (e.g., skills training in coping, relaxation)

Reference: Hoge 2011

Implementation

- If veteran is willing and able, deliver trauma-focused treatment
- Encourage trauma-focused work but respect veteran's judgment
- Give multiple options for exposure work (written, imaginal)
- For some veterans, may want to vary timing and order of different components

Marital Issues

- Provide psychoeducation regarding common post-deployment issues and tips on how to deal with them to spouses
  - Battlemind for spouses
  - National Center for PTSD website (www.ncptsd.va.gov)
- Recognize and validate stress spouse has experienced
- Spouse support groups

Marital Therapy

- Cognitive-behavioral conjoint therapy for PTSD *(Monson & Fredman, 2012)*
- Manualized couple therapy for patients with PTSD and their significant others
- Focus is on treating PTSD symptoms and enhancing relationship satisfaction simultaneously

Guilt

"We are reluctant to admit that essentially war is the business of killing"…(while the soldier himself) "comes from a civilization in which aggression, connected with the taking of life, is prohibited and unacceptable."

Quote by S.L.A. Marshall, excerpted from article by Dan Baum, The Price of Valor,

Reference: The New Yorker, July 2004

Approaches to Treating Combat Related Guilt

- Convey openness to listen to all experiences without judgment
- Cognitive model of guilt typology (Kubany, 1994)
  - Negligence/betrayal/abandonment
  - Incompetence
  - Feeling pleasure or nothing after killing
  - Atrocity guilt

Guilt

- Cognitive therapy for guilt (Kubany & Manke,1995)
- Manual based on these principles developed by Allard, Norman, and Wilkins (San Diego VA): Trauma Informed Guilt Reduction

Trauma Informed Guilt Reduction

- Evaluate thinking errors that can lead to faulty conclusions regarding beliefs about
  - Foreseeability and preventability
  - Insufficient justification
  - Degree of responsibility
  - Violation of values

Guilt

- Preliminary model and intervention strategy for moral injury and moral repair (Litz et al., 2009)
- Routes to moral repair
  - Psychological and emotional processing of incident(s)
  - Exposure to corrective life experience (increasing positive judgments about the self and world by doing and seeing others do good deeds)

Anger and Aggression

- Cognitive behavioral treatment of anger (Novaco)
- Small study in Vietnam War Veterans with positive results
- Manual adapted for anger problems in OEF/OIF veterans
- Promising results in pilot study (Shea et al., under review)

Final Comments

- Psychological health problems are common and undertreated among returning veterans
- May be particularly true for NG/R veterans, who as “civilian soldiers” may experience unique forms of stress during deployment and reintegration
- Continued work on innovative ways of engaging, treating and supporting these veterans is critical

References

Belasco A (2007). *The Cost of Iraq, Afghanistan, and Other Global War on Terror Operations Since 9/11.* Washington, D.C.: Congressional Research Service.

Elbogen EB, Wagner HR, Johnson SC, Kinneer P, Kang H, Vasterling JJ, Timko C, Beckham JC (2013). Are Iraq and Afghanistan Veterans using mental health services? New data from a national random-sample survey. *Psychiatric Services*, *Psychiatry online*, Feb 01, 2013.

Erbes C, Westermeyer J, Engdahl B, Johnsen E (2007). Posttraumatic stress disorder and service utilization in a sample of service members from Iraq and Aghanistan. *Military Medicine*, 172, 359-363.

Friedman MJ (2005). Veterans' Mental Health in the Wake of War. *New England Journal of Medicine,* 352, 1287-1289.

Hoge CW (2011). Interventions for war-related posttraumatic stress disorder. Meeting veterans where they are. *Journal of the American Medical Association*, 306, 549-551.

Hoge CW, Auchterlonie JL, Milliken CS (2006). Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. *Journal of the American Medical Association*, 295, 1023-1032.

Hoge CW, Castro CA, Messer SC, McGurk D, Cotting DI, Koffman RL (2004). Combat dury in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine*, 351, 13-22

References

Khaylis A, Polusny MA, Erbes CR, Gewirtz A, Rath M (2011). Posttraumatic stress, family adjustment, and treatment preferences among national guard soldiers deployed to OEF/OIF. *Military Medicine*, 176, 126-131.

Kim PY, Thomas JL, Wilk JE, Castro CA, Hoge CW (2010). Stigma, barriers to care, and use of mental health services among active duty and national guard soldiers after combat. *Psychiatric Services*, 61, 582-588.

Kubany ES (1994). A cognitive model of guilt typology in combat-related PTSD. *Journal of Traumatic Stress*, 7, 3-19.

Kuban ES, Manke FM (1995). Cognitive therapy for trauma-related guilt: Conceptual bases and treatment outlines. *Cognitive and Behavioral Practice*, 2, 27-61.

Litz BT, Stein N, Delaney E, Lebowitz L, Nash WP, Silva C, Maguen S (2009). Moral injury and moral repair in war veterans: A preliminary model and intervention strategy. *Clinical Psychology Review*, 29, 695-706.

Monson CM, Fredman SJ (2012). *Conjoint Therapy for Posttraumatic Stress Disorder: Harnessing the Healing Power of Relationships*. New York, NY: Guilford Press.

Milliken CS, Auchterlonie JL, Hoge CW (2007). Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq War. *Journal of the American Medical Association*, 298, 2141-2148.

References

Sayer NA, Noorbaloochi S, Frazier P, Carlson K, Gravely A, Murdoch M (2010). Reintegration problems and treatment interests among Iraq and Afghanistan combat veterans receiving VA medical care. *Psychiatric Services*, 61, 589-597.

Schell TL, Marshall GN (2008). Survey of individuals previously deployed for OEF/OIF. In Tanielian, T and Jaycox LH (Eds.) *Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery (pp 87-115).*

Seal KH, Maguen S, Cohen B, Gima KS, Metzler TJ, Ren L, Bertenthal D, Marmar CR (2010). VA mental health services utilizations in Iraq and Afghanistan Veterans in the first year of receiving new mental health diagnoses. *Journal of Traumatic Stress*, 23, 5-16.

Thomas JL, Wilk JE, Riviere LA, McGurk D, Castro CA, Hoge CW (2010). Prevalence of mental health problems and functional impairment among active component and national guard soldiers 3 and 12 months following combat in Iraq. *Archives of General Psychiatry*, 67, 614-623.

Other:

Battlemind Training. WRAIR Land Combat Study Team, Walter Reed Army Institute of Research (WRAIR).

Military Cultural Competence Training: www.essentiallearning.net

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Posttraumatic Stress Disorder Clinical Support Tools

George Lamb, LCSW

Social Work Consultant; Outreach Chief, Public Affairs, Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury

DVBIC Defense and Veterans Brain Injury Center
DHCC Deployment Health Clinical Center
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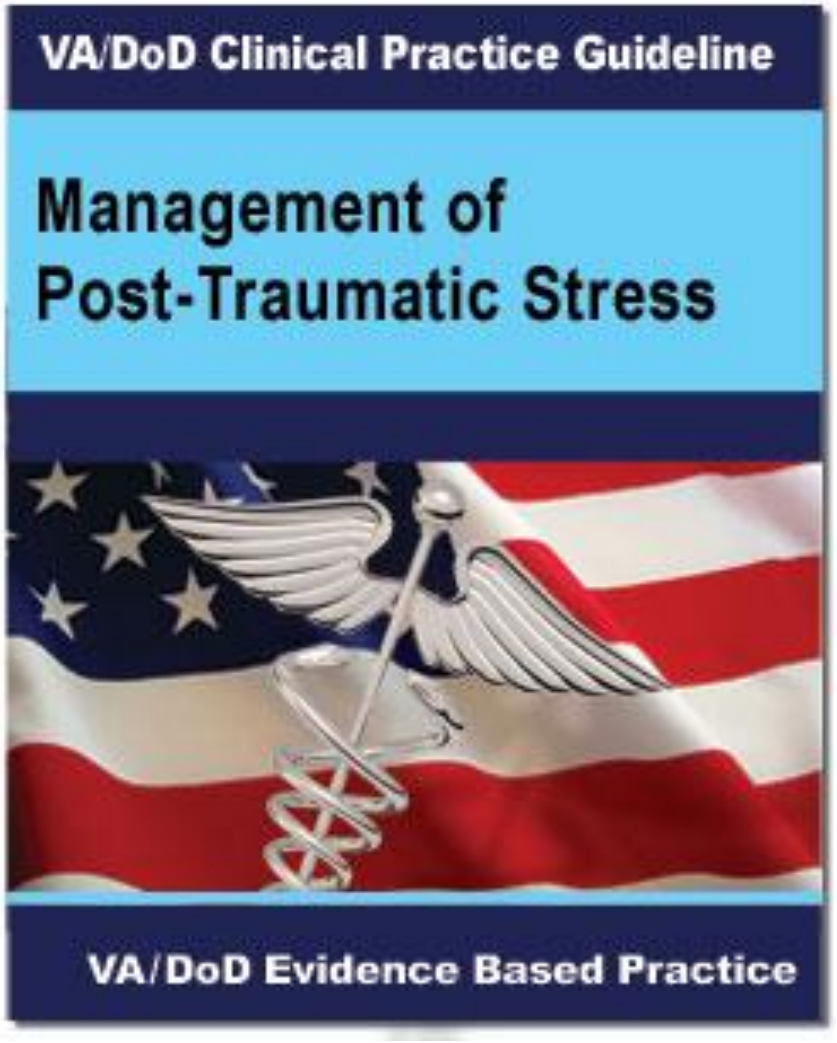
Management of Post-traumatic Stress



Support Tools for Post-traumatic Stress

Tool	Target Audience
Understanding Posttraumatic Stress Disorder	Patients and families
Experiencing Posttraumatic Stress Disorder as a Family: A Guide to Thrive	Families
VA/DoD Essentials for Posttraumatic Stress Disorder: Provider Tool	Health care providers
Posttraumatic Stress Disorder Pocket Guide: To Accompany the VA/DoD Clinical Practice Guideline for the Management of Post-traumatic Stress	Health care providers
Implementing the 2010 VA/DoD Clinical Practice Guideline for Post-traumatic Stress: A Guide for Clinic Leaders	Program administrators and clinic managers

Resources

- To download electronic versions of the clinical practice guideline (CPG) and clinical support tools (CSTs), visit:
  - https://www.qmo.amedd.army.mil
  - www.healthquality.va.gov/

- To order hard copies of the CPG or CSTs for patients and families, visit the U.S Army Medical Command website at https://www.qmo.amedd.army.mil
  - Tools will be available for order for military treatment facilities in 60 to 90 days

Thank you, questions?

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